BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of: **DARRELL J. JESSOP, M.D.,** Holder of License No. 23441 for the Practice of Allopathic Medicine in the State of Arizona, Respondent.	**No.: 11A-23441-MDX** **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** ***(LETTER OF REPRIMAND, PROBATION AND PRACTICE RESTRICTION)***

On February 1, 2012, this matter came before the Arizona Medical Board ("Board") for consideration of the Administrative Law Judge ("ALJ") Diane Mihalsky's proposed Findings of Fact, Conclusions of Law and Recommended Order. Darrell J. Jessop, M.D. ("Respondent") appeared before the Board without legal counsel; Michael W. Sillyman, represented the State. Christopher Munns with the Solicitor General's Section of the Attorney General's office, was present and available to provide independent legal advice to the Board.

The Board, having considered the ALJ's decision and the entire record in this matter, hereby issues the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

BACKGROUND AND PROCEDURE

1. The Arizona Medical Board ("the Board") is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.

2. The Board issued License No. 23441 to Darrell J. Jessop, M.D. ("Respondent") for the practice of allopathic medicine in the State of Arizona.

3. In approximately 2007 and 2008, the Board received three complaints from patients regarding Respondent's prescription of controlled substances (Case Nos. MD-07-0189A, MD-07-1027A, and MD-08-1090A). While the Board was investigating the three

complaints, on June 16, 2008, Respondent entered into an Interim Consent Agreement for Practice Restriction ("Interim Consent Agreement") that restricted him from prescribing any more than 30 short-acting opioids per patient, with no refills. After the Board obtained a pharmacy survey to monitor Respondent's compliance with the Interim Consent Agreement, the Board determined that he wrote prescriptions that either violated the Interim Consent Agreement or the standard of care. As a result, the Board initiated a fourth complaint (Case No. MD-08-0467A).

4. On April 14, 2010, the Board and Respondent entered into a Consent Agreement for Decree of Censure, Probation, and Practice Restriction ("the Consent Agreement"). In the Consent Agreement, Respondent admitted to the entry of Conclusions of Law that concluded that he had committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(e),[1] (q),[2] and (ii)[3] in the following respects: (a) By prescribing numerous escalating doses of Methadone, Oxycontin, Demerol, Oxycodone, Actiq, and Hydrocodone to a patient who presented with subjective complaints of pain, even though clinical tests only showed that the patient had mild degenerative changes (Case No. MD-07-0189A); (b) Prescribing escalating doses of opioids, antidepressants, muscle relaxants, stimulants, and anxiolytics to a patient without reviewing past medical records or consulting with the patient's other health care providers, which contributed to the patient's death (Case No. MD-07-1027A); (b) Prescribing numerous escalating doses of Percocet, Hydromorphone, Fexeril, Baclofen, Demerol, and Oxycodone to a patient without obtaining or reviewing any past medical records, diagnostic imaging, or special consultations, which led the patient to overdose and to require ventilatory support (Case No. MD-08-1090A); and (d) Twice prescribing 60 Vicodin to a patient, in violation of the Interim Consent Agreement, prescribing and administering trigger point injections to the patient without documenting the

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[1] A.R.S. § 32-1401(27)(e) defines unprofessional conduct as "[f]ailing or refusing to maintain adequate records on a patient."

[2] A.R.S. § 32-1401(27)(q) defines unprofessional conduct as "[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public."

[3] A.R.S. § 32-1401(27)(ii) defines unprofessional conduct as "[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient."

spasticity associated with an upper motor neuron disorder, in violation of the standard of care, and prescribing Tylenol #3 to another patient, in violation of the Interim Consent Agreement (Case No. MD-09-0467A). Respondent also admitted that he committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(r)[4] and (jj).[5]

5. In the Consent Agreement, Respondent agreed to a Practice Restriction, in relevant part as follows:

> a. Respondent is prohibited from prescribing, administering or dispensing any controlled substances for a period of three years (please see (c.) below).
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> ....
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> c. This restriction does not preclude Respondent from administering controlled substances in life-threatening emergencies.[6]

6. Before the Board accepted the Consent Agreement, its members and staff engaged in a discussion of the meaning of the exception set forth in section 2.c. of the Practice Restriction, as summarized in the Board's meeting minutes as follows:

> Dr. Pardo noted that the Agreement does not preclude [Respondent] from administering controlled substances in life-threatening situations. Ms. Froedge reported that [Respondent] currently works in an urgent care setting, and that there were concerns regarding the prescribing restriction; therefore, the Practice Restriction does not prohibit [Respondent] from administering controlled substances in life-threatening situations. Board members noted that [Respondent] will be the one to determine whether a situation is life-threatening and whether a patient requires emergency administration of controlled substances. Board staff pointed out that if [Respondent's] judgment is incorrect, he will be held accountable for violating the Order.[7]

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[4] A.R.S. § 32-1401(27)(r) defines unprofessional conduct as "[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter."

[5] A.R.S. § 32-1401(27)(jj) defines unprofessional conduct as "[k]nowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board."

[6] The Board's Ex. 6 at AMB 00014 (footnote added).

[7] The Board's Ex. 7 at AMB 00376 (footnote added).

7. On December 6, 2010, the Board initiated Case No. MD-11-0001A after Board staff conducted a pharmacy survey to monitor Respondent's compliance with the Consent Agreement and discovered that Respondent had prescribed the controlled substance Lomotil in apparent violation of the Consent Agreement. Board staff performed an investigation and the matter was evaluated by the Board's medical consultant. Based on the evidence, the Board's Staff Investigational Review Committee recommended that the Board refer the matter to formal hearing for revocation if Respondent declined to surrender his license.[8]

8. The Board referred the matter to the Office of Administrative Hearings ("the OAH"), an independent state agency, for an evidentiary hearing. On September 29, 2011, the Board issued a Complaint and Notice of Hearing, charging Respondent with committing unprofessional conduct as defined by A.R.S. § 32-1401(27)(e), (q), (r), and (t).

9. A hearing was held in Case No. MD-11-0001A in the OAH on December 9, 2011. The Board submitted 35 exhibits and presented the testimony of three witnesses: (1) Erinn Downey, the Board's investigator assigned to the case; (2) Michael Yim, M.D., the Board's medical consultant, who reviewed the patient records and rendered a report on whether Respondent's care of the patients deviated from the standard of care or violated the Consent Agreement; and (3) Respondent. Respondent submitted seven exhibits and presented the testimony of five witnesses: (1) Jane M. Orient, M.D., the Executive Director of the Association of American Physicians and Surgeons and an instructor at the University of Arizona Medical School, who testified on the standard of care, practice in an urgent care clinic, and whether Respondent violated the Consent Agreement; (2) Nasser Hajaig, M.D., the Medical Director of Advanced Urgent Care, which employed Respondent at the time he wrote the prescriptions at issue; (3) Carlos Moe, D.O., Respondent's colleague at Advanced Urgent Care, who reviewed the cases at issue and issued a report to the Board on whether Respondent met the standard of care for an urgent care physician; and (4) Scott Forrer, M.D., who reviewed the Consent Agreement and testified as to the meaning of prescribing and administering in the medical profession.

[8] *See* the Board's Ex. 9.

HEARING EVIDENCE

Administering and Prescribing in an Urgent Care Setting

10. The Urgent Care Association of America has defined urgent care to mean "medically necessary services that are required for an illness or injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours."[9]

11. The article that Respondent submitted to define the scope of practice in an urgent care clinic also stated in relevant part:

> Urgent care centers are just a step below an emergency room as far as services and capabilities go. Non-emergency care is the best way to define what urgent care facilities do. However, for scenarios that cannot be handled in most urgent care centers, such as uncontrollable bleeding, treatment for heart attacks and strokes and other dire injuries or illnesses that will require in-depth care, traditional emergency department services are suggested.[10]

12. Dr. Orient testified that because an integral part of an urgent care practice is writing prescriptions for patients to prevent possibly life-threatening complications after the patient leaves the clinic, "administering" a medication is not necessarily any different from "prescribing" it. Dr. Orient opined that because the Consent Agreement did not require that an emergency pose a risk of a patient's "imminent" death, the Consent Agreement did not prohibit Respondent's prescription of controlled substances to patients whose condition might substantially deteriorate, in his opinion.

13. Dr. Hajaig testified that physicians in an urgent care clinic tend to see higher acuity patients than they would see in a family practice. Dr. Hajaig testified that, therefore, physicians in an urgent care practice may be more aggressive in their treatment and that it is up to the physician to determine if a patient has a life-threatening condition.

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[9] Respondent's Ex. 11.
[10] Respondent's Ex. 11.

14. Dr. Forrer opined that because the Consent Agreement did not define what it means to "administer" a drug, as opposed to "prescribing" a drug, the document was ambiguous because a physician cannot administer a drug without first prescribing it. Dr. Forrer testified that a physician may personally administer a drug to a patient, or direct someone under his guidance, such as a parent, to administer the drug. Dr. Forrer testified that administering a drug is always secondary to prescribing it.

15. Respondent testified that it would not make sense for a physician to administer a single dose of a medication. Respondent testified that because once a patient returns home, he or she is usually "lost to" the care of an urgent care clinic physician, the physician must do everything in his or her power to assure a good outcome, including writing prescriptions for the patient to obtain medication he or she can take after leaving the clinic.

Respondent's Prescription of Two Forms of Promethazine to Patient AV

16. AV was a 62-year-old patient who presented to Advanced Urgent Care on May 13, 2010, with complaints of vomiting, diarrhea for three days, and cough for two weeks.[11]

17. Respondent wrote prescriptions for several drugs for AV, including Phenergan (promethazine), Lomotil (diphenoxylate/atropine), and Phenergan DM (promethazine with dextromethorphan).

18. Dr. Yim opined that Respondent deviated from the standard of care by prescribing two forms of promethazine to AV, which could have resulted in an overdose and significant sedation because AV could have taken as much as 62.5 mg of promethazine. Dr. Yim opined further that Respondent's prescription that added the diphenoxylate to the promethazine could worsen the sedative side effects.[12]

19. The pharmacy survey did not indicate that AV actually filled both prescriptions for promethazine.[13] Respondent testified that contrary to his treatment note, he withheld one of the prescriptions from AV.

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[11] *See* the Board's Ex. 13 at AMB 00147.
[12] *See* the Board's Ex. 15 (Dr. Yim's medical consultant's report).
[13] *See* the Board's Ex. 14 at AMB 00392.

20. Dr. Yim noted that Respondent was under a practice restriction that prohibited him from prescribing controlled substances. Dr. Yim opined that Respondent could have prescribed substances to treat AV's symptoms, such as loperimide (Imodium), because there were no documented allergies, treatment failures, or treatments refused by the patient.

21. Dr. Moe opined that AV presented to Advanced Urgent Care with a life-threatening emergency, in relevant part as follows:

> Older patients who lose fluids rapidly through diarrhea and vomiting can go on to develop cardiogenic shock this [*sic*] can also trigger a myocardial infarction if the heart cannot maintain a high enough heart rate to makeup for significant fluid losses. The emergency use of lomotil in this case prevented the patient for [*sic*] needing hospitalization and treatment for cardiogenic shock [*sic*][14]

Respondent's Prescription of Lomotil to Pediatric Patients

22. Between May 13, 2010, and June 9, 2010, Respondent treated six pediatric patients who presented to Advanced Urgent Care with complaints of diarrhea: TM (2 years old); IH (5 years old); LH (7 years old); BH (3 years old); JE (11 years old); and LV (16 months old). Respondent's treatment notes stated that all six pediatric patients were active, attentive, alert, and not in acute distress, and none of the patients exhibited symptoms of dehydration, such as dry mucous membranes, sunken eyes or elevated pulse.[15]

23. Respondent prescribed the controlled substance of Lomotil, an anti-motility drug, to all six pediatric patients.

24. Dr. Yim opined that Respondent's prescription of Lomotil to TM deviated from the standard of care. Dr. Yim's medical consultant's report stated in relevant part:

> Although there is an approved FDA indication for diphenoxylate/atropine [Lomotil] to be given in pediatric dosages, [Respondent's prescription] is a deviation from the pediatric standard of care. The Harriet Lane Handbook, the standard manual

[14] The Board's Ex. 16 at AMB 00291.

[15] *See* the Board's Ex. 21 at AMB 00182 (TM) ("The patient is active, attentive and in no acute distress"); Ex. 23 at AMB 00186 (IH) ("The patient is active, attentive and in no acute distress"); Ex. 25 at AMB 00194 (LH) ("The patient is active, attentive and in no acute distress"); Ex. 27 at AMB 00200 (BH) ("Alert, in no acute distress").

for pediatric house officers, does not recommend medical treatment for diarrhea, stating

> "Oral rehydration therapy (ORT) is almost always successful and should be attempted with an appropriate oral rehydration solution in cases of mild to moderate dehydration... Parenteral hydration is indicated in severe dehydration, hemodynamic instability, or failure of ORT."

Actual Harm Identified: There was no actual harm identified.

Potential Harm Identified: There was significant potential harm identified. In "Prevention and treatment of viral gastroenteritis in children" from Uptodate.com, the authors note that

> "Opiate receptor agonists, such as loperamide and diphenoxalate-atropine combinations reduce intestinal luminal motility. Such agonists have significant side effects, including lethargy, paralytic ileus, toxic megacolon, central nervous system depression, coma, and even death. In addition, because they delay transit time, they have been shown to prolong the course of bacterial diarrheas, such as shigella and Escherichia coli 0157:H7."
> ....

Consultant's Summary: This evaluator feels that [Respondent's] treatment did not meet the standard of care. There were no documented signs of severe dehydration as a result of the child's diarrhea. The pulse was not elevated, the ocular exam was normal to inspection (eyes were not sunken), and the mucus membranes were moist. As such, the use of any medications for diarrhea fell well outside the standard of care, and the use of antimotility agents even more so given the higher risks associated with their use.[16]

25. For the same reasons, Dr. Yim opined that Respondent's prescription of Lomotil to pediatric patients IH,[17] LH,[18] BH,[19] JE,[20] and LV[21] deviated from the standard of care.

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[16] The Board's Ex. 15 at AMB 00128-29.
[17] *See id.* at AMB 00130-31.

26. Dr. Moe issued a report opining that Respondent's prescription of Lomotil to pediatric patient TM did not deviate from the standard of care, opining in relevant part as follows:

> Writing for Lomotil . . . is related to the patients age [*sic*] young patients are at higher risk for developing severe dehydration from fluid losses that can result in cardiovascular collapse [*sic*] their vital signs can remain normal up to independing [*sic*] cardiovascular collapse so emergency treatment is initiated based on examination and assessment of the patient rather than by the patient's current vital signs.[22]

27. For the same reasons, Dr. Moe opined that Respondent's prescription of Lomotil to patients IH, LH, BH, and JE did not deviate from the standard of care.[23] However, as to LV, the 18-month-old patient, Dr. Moe opined that Respondent deviated from the standard of care because usually oral rehydration is sufficient and Lomotil was only recommended for children who were older than 2 years of age.[24]

28. Respondent testified that LV was 18 months old and was a large child, within the 75th or 95th percentile for weight.

29. Dr. Orient testified that diarrhea can be life-threatening for children because it can cause severe dehydration and that Lomotil prevents dehydration by reducing the number of bowel movements by up to 80%. Dr. Orient testified that many authorities recommend Lomotil for pediatric patients due to the "difficulty of getting liquids into children." Dr. Orient testified that she could not opine whether Respondent deviated from the standard of care with respect to a particular patient unless she personally examined the patient.

30. The authorities that Respondent submitted either did not involve pediatric patients who did not exhibit symptoms of dehydration[25] or expressly cautioned against the

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[18] *See id.* at AMB 00131-32.
[19] *See id.* at AMB 00132-33.
[20] *See id.* at AMB 00134-35.
[21] *See id.* at AMB 00136-37.
[22] The Board's Ex. 16 at 292.
[23] *See id.* at AMB 00 292-93.
[24] *Id.* at AMB 00293.
[25] *See* Respondent's Ex. 10 ("Guidelines on Acute Infectious Diarrhea in Adults," THE AMERICAN JOURNAL OF

use of antimotility drugs such as Lomotil for pediatric patients for the reasons stated in Dr. Yim's medical consultant's report.[26]

31. Dr. Hajaig sent a letter to the Board in support of Respondent that opined that Respondent's "use of Lomotil was judicious and appropriate."[27] Dr. Hajaig testified that although oral rehydration is the mainstay for acute diarrhea in pediatric patients, he felt that Respondent's prescription of Lomotil to the pediatric patients did not deviate from the standard of care, with the exception of the prescription to LV. Dr. Hajaig acknowledged that none of the six pediatric patients to whom Respondent prescribed Lomotil exhibited any symptoms of life-threatening dehydration, but testified that all of the patients "could have taken a turn for the worse" after they left Advanced Urgent Care.

32. Dr. Yim opined that "FDA approval of a medication, as opposed to the actual use of the medication as standard of care, are not equivalent"[28] and pointed out that because FDA did not approve use of Lomotil for patients under two years old, Respondent's prescription of Lomotil to LV was contraindicated.

33. Dr. Hajaig testified that the fact that a drug was not recommended for a particular circumstance did not mean that prescription of the drug was contraindicated or a deviation from the standard of care. Dr. Hajaig testified that if a patient is stable, an urgent care physician could prescribe medication for the patient but that if the patient was not stable, the physician should send the patient to an emergency room. Dr. Hajaig testified that he does not prescribe Lomotil to his pediatric patients.

34. Dr. Moe testified that the good appearance of the pediatric patients did not mean that Lomotil was not indicated because "medicine cannot be practiced in a phone booth" and a young person will dilate blood vessels to maintain output, then "crash" when the blood vessels constrict. Dr. Moe testified that a physician must take into account the duration of the symptoms when prescribing medication because every sick child is at risk for

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GASTROENTEROLOGY vol. 92, No. 11 at 1962 (1997)).

[26] *See* Respondent's Ex. 20 (Matson, "Prevention and treatment of viral gastroenteritis in children") at 2.

[27] The Board's Ex. 18.

[28] The Board's Ex. 19 at AMB 0082.

developing a life-threatening condition. Although Dr. Moe acknowledged that none of pediatric patients to whom Respondent prescribed Lomotil exhibited symptoms that would indicate a life-threatening condition, he testified that patient evaluation is not "cut and dried" and that it is better for the physician to treat the patient than to "let them die two hours later."

35. Dr. Moe testified that recent literature that stated that Lomotil was not recommended for pediatric patients was not indicative of the standard of care. Dr. Moe testified that he usually does not prescribe Lomotil to his pediatric patients but, instead, gives them an over-the-counter medication such as Imodium.

36. Respondent acknowledged that he did not advise any of the pediatric patients to go to the emergency room, but instead sent them home with a prescription for Lomotil and aftercare instructions for hydration. Respondent stated that many parents refuse to take their children to the emergency room because of the long wait or concerns about added expense, and treating physicians at urgent care centers have no way to determine whether parents will seek appropriate follow-up care, even when they are instructed to do so. Respondent testified that it would be irresponsible to wait until a pediatric patient was "dry as a potato chip" before prescribing an antimotility drug such as Lomotil.

Respondent's Statements Regarding Patient JL

37. On March 3, 2010, before Respondent signed the Consent Agreement, he treated patient JL for a toothache at Advanced Urgent Care and prescribed hydrocodone/acetaminophen, a controlled substance, to treat her pain.[29]

38. The survey that the Board later obtained from Walgreen's Pharmacy indicated that on April 16, 2010, a refill of 20 hydrocodone pills was authorized by "Monica" under Respondent's DEA number. Neither the patient request nor the refill was documented in JL's chart at Advanced Urgent Care.

39. In a letter that the Board received on January 24, 2011, responding to the allegations in Case No. MD-11-0001A, Respondent denied having authorized a refill for JL

[29] *See* the Board's Ex. 34 at AMB 00251.

and stated that he was not assigned to the Advanced Urgent Care clinic to which the refill request fax was sent on the date that "Monica" allegedly approved the refill.[30]

40. Dr. Yim opined in the medical consultant's report that Respondent's handling of the unauthorized refill deviated from the standard of care, in relevant part as follows:

> First and foremost, refills are almost never provided in an urgent care setting, and any such interactions would require documentation. Secondly, any prescriptions or refills made under a provider's DEA number are that provider's responsibility. Nearly every provider has experienced situations where a prescription or refill has been falsified or improperly given under their name. When notified that such a situation has occurred, the provider has a responsibility to determine the cause, and respond to it by determining what has occurred and responding appropriately.
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> In this case, although [Respondent] determined that no 'Monica' was at Advanced Urgent Care on staff at the time of the refill authorization, there was no documentation of a wider staff investigation at Advanced Urgent Care or a police report. Given the seriousness of [Respondent's] practice restriction, that would seem to be a high priority in order to prevent any such event from reoccurring in the future. As things stand, this event could occur again in the future and [Respondent] could claim ignorance and disavow responsibility for violating his practice restriction in the future.[31]

41. On or about March 30, 2011, Respondent sent the Board a letter in response to Dr. Yim's medical consultant's report. With respect to Dr. Yim's criticism of the way he handled JL's unauthorized refill of the hydrocodone prescription, Respondent stated, "For the record, the situation regarding this patient was fully discussed with the Medical Director, Dr Hajaig, and the appropriate pharmacies, satellite clinics and law enforcement personnel were notified."[32]

42. On or about April 21, 2011, Dr. Yim issued a report of his review of the additional materials that Respondent had provided. With respect to Respondent's response

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[30] *See* the Board's Ex. 12 at AMB 00301-02.
[31] The Board's Ex. 15 at AMB 00138 (footnote added).
[32] The Board's Ex. 17 at AMB 00390.

to the criticism of his initial handling of JL's unauthorized refill of the hydrocodone prescription, Dr. Yim noted that Respondent's alleged notification to Dr. Hajaig, the pharmacy, satellite clinics, and law enforcement personnel would meet the standard of care, "except there is no documentation as proof."[33]

43. On or about May 30, 2011, Respondent supplemented his response to Dr. Yim's medical consultant's report to inform the Board that his last day of employment at Advanced Urgent Care was June 11, 2010, when the DEA took his registration, and that he had been informed that JL had been terminated as a patient. Respondent's supplemental response provided further in relevant part:

> My past experience with similar situations at Advanced Urgent Care was that the Medical Director was the only person who could terminate patient care. It would be he that would notify the other clinics by adding a note to the patient's medical record stating that the patient would no longer be treated at Advanced Urgent Care. If he determined that the situation warranted it, he may contact law enforcement personnel. I can only assume that he followed through as I stated as I had no opportunity to follow-up myself.
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> It is important to note that after June 11, 2010 I would not be able to add anything to the patient's record about this situation as I was no longer employed by Advanced Urgent Care and therefore not legally entitled to do so. . . .[34]

44. Dr. Hajaig testified that he did not remember whether Respondent did everything he could to rectify the situation after he learned that JL had obtained an unauthorized refill prescription for hydrocodone. Dr. Hajaig testified that although Advanced Urgent Care's policy was to notify authorities in cases of unauthorized refills, there was nothing in the system to indicate such notification to authorities in JL's case.

CONCLUSIONS OF LAW

1. The Board has jurisdiction to consider this complaint and to discipline Respondent's license to practice allopathic medicine in Arizona.[35]

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[33] The Board's Ex. 19 at AMB 0082.
[34] The Board's Ex. 35 at AMB 00457.
[35] *See* A.R.S. § 32-1451.

2. The Board bears the burden of proof and must establish cause to discipline Respondent's license by a preponderance of the evidence.[36] Respondent bears the burden to establish affirmative defenses by the same evidentiary standard.[37]

3. "A preponderance of the evidence is such proof as convinces the trier of fact that the contention is more probably true than not."[38]

4. Respondent and his witnesses testified that in an urgent care practice, protecting the well-being of the patient requires the physician to prescribe drugs that would later be administered pursuant to the physician's order. Respondent and his witnesses testified that as a result, the Practice Restriction in the Consent Agreement was ambiguous. Respondent's interpretation eliminates the unconditional prohibition on prescribing controlled substances in paragraph (a) and allows him to write a prescription under paragraph (c) anytime he deems that a life-threatening emergency exists. Respondent and his witnesses also testified that a "life-threatening emergency" in medicine is anytime that the practitioner in his sole discretion determines that the patient's condition might deteriorate if he does not prescribe medication to be administered at the patient's home.

5. "Prescribing" and "administering" a drug are separate, distinct activities, both in the lexicon[39] and the law.[40] An emergency is "[a] situation or occurrence of a serious nature, developing suddenly and unexpectedly, and demanding immediate action."[41] Under Respondent's own authorities, an urgent care clinic is not equipped to handle life-threatening emergencies and if such an emergencies arise, the urgent care physician must refer the patients to an emergency room.

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[36] *See* A.R.S. § 41-1092.07(G)(2); A.A.C. R2-19-119(A) and (B)(1); *see also Vazanno v. Superior Court*, 74 Ariz. 369, 372, 249 P.2d 837 (1952).

[37] *See* A.A.C. R2-19-119(B)(2).

[38] Morris K. Udall, ARIZONA LAW OF EVIDENCE § 5 (1960).

[39] Compare THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE at 1035 (To prescribe in medicine is to write an order, especially by a physician, for the preparation and administration of a medicine) (1973) *with* www.macmillandictionary.com (To administer is to give someone a drug or medical treatment).

[40] *See* 1985 Op. Ariz. Atty. Gen. 43 (1985) and Ariz. Atty. Gen. Op. 79-095 (1979) (construing various statutes that allow physicians, nurse practitioners, and medical assistants to prescribe medications and nurses and others under their supervision to administer the medications).

[41] THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE, supra, at 427.

6. The Consent Agreement is a contract between the Board and Respondent. A contract must be construed to give effect to every part and to bring harmony, if possible, between all parts of the writing.[42] "A contract should be read in light of the parties' intentions as reflected by their language an in view of all the circumstances. If the intention of the parties is clear from such a reading, there is no ambiguity."[43] Under these authorities, the Board established that Respondent violated the Consent Agreement and committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(r) when he prescribed promethazine and Lomotil to AV and when he prescribed Lomotil to TM, IH, LH, BH, JE, and LV.

7. The standard of care generally is "what is recognized as acceptable in the community of physicians involved in [a] practice" and may consider individual physicians' personal approaches to patient care.[44] Dr. Yim credibly testified that pediatric patients who do not exhibit any symptoms of dehydration should not be given Lomotil due to the potential side effects. Neither Dr. Hajaig nor Dr. Moe would have prescribed Lomotil to TM, IH, LH, BH, JE, or LV. No medical treatises were submitted that advised or approved Lomotil for pediatric patients who presented with TM's, IH's, LH's, HB's, or JE's symptoms and under the FDA standards, prescription of Lomotil to LV was contraindicated. Therefore, the Board established that Respondent committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(q)[45] when he prescribed Lomotil to TM, IH, LH, BH, JE, and LV.

8. The medical record that Respondent prepared for AV showed that two forms of promethazine were prescribed. Respondent did not establish that he gave only one prescription to AV, and it appears equally likely that the fact that the pharmacy only filled one prescription was fortuitous (and fortunate for AV). Therefore, the Board established that Respondent committed additional unprofessional conduct as defined by A.R.S. § 32-1401(27)(q) when he prescribed two forms of promethazine to AV.

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[42] *Gesina v. General Electric Company*, 162 Ariz. 39, 45, 780 P.2d 1380, 1386 (App. 1988).
[43] *Smith v. Melson, Inc.*, 135 Ariz. 119, 121, 659 P.2d 1264, 1266 (1983) (citations omitted).
[44] *Smethers v. Campion*, 210 Ariz. 167, 175 ¶ 28 and n.7, 108 P.3d 946, 954 (App. 2005) (citing authorities).
[45] *See* note 3, *supra*.

9. On or about March 30, 2011, Respondent stated categorically that law enforcement had been contacted about JL's unauthorized refill of the prescription for hydrocodone. Two months later, Respondent stated that he believed that Dr. Hajaig may have reported the unauthorized prescription to law enforcement. Respondent did not present any evidence at hearing that anyone had contacted law enforcement about the unauthorized prescription refill.

10. "'Knowingly' imports only a knowledge that the facts exist which bring the act or omission within the provisions of the statute using such word. It does not require any knowledge of the unlawfulness of the act or omission."[46] Because Respondent should have known that his categorical statement to the Board that law enforcement had been notified was false, the Board established that Respondent committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(t).[47]

ORDER

Based on the foregoing, and on the effective date of this Order, it is the Order of this Board that a Letter of Reprimand be issued to Respondent Darrell J. Jessop, M.D., License No. 23441. It is further ordered, as of the effective date of this Order, that Respondent be placed on a 5 year probation and practice restriction under which he is restricted from prescribing any controlled substance for a period of 5 years. Such restriction to be monitored by Board Staff. It is further ordered that Respondent shall complete 20 hours of a Board approved CME course in pediatric emergencies within 6 months from the effective date of this Order. The CME shall be in addition to the CME required for license renewal.

Pursuant to A.R.S. § 32-1451.M., Respondent is charged the costs of the formal hearing. Respondent shall pay those costs to the Board no later than 90 days from the effective date of this Order.

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[46] A.R.S. § 1-215(17).

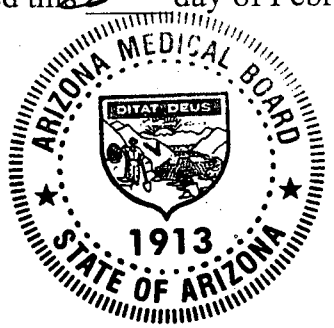
[47] A.R.S. § 32-1401(27)(t) defines unprofessional conduct as "[k]nowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution."

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09.B. The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.S.C. R4-16-103. Service of this Order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09.C. If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

Dated this 7th day of February, 2012.



THE ARIZONA MEDICAL BOARD

Lisa Wynn, Executive Director

ORIGINAL of the foregoing filed this 7th day of February, 2012, with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

COPY of the foregoing filed this 7th of February 2012, with:

Cliff J. Vanell, Director
Office of Administrative Hearing
1400 W. Washington, Ste. 101
Phoenix, AZ 85007

Executed copy of the foregoing mailed by U.S. Mail this 6th day of February 2012, to:

Darrell J. Jessop, M.D.
Address of Record

Michael W. Sillyman, Esq.
Kutak Rock LLP
8601 N. Scottsdale Rd. Ste 300
Scottsdale, AZ 85253-2742

Attorney for the State